Memorandum of Understanding

Thank You for Confirming Your Interest In The

TRICARE Area Office Europe

Preferred Provider Bariatric Surgeon Network

Provider Application Instructions

1. Please review the Memorandum of Understanding and place your signature, business stamp and date on page 3 (C9.a).
2. Complete page 4 (data sheet) and page 5 (credential summary)

Please send the completed MOU, together with your resume, your license, and other specific Credentials identified on page 3, C1 to:

The TRICARE Europe Office,
Attn: Clinical Operations
Sembach Flugplatz, Geb 214,
67681 Heuberg, Germany

Questions related to the Preferred Provider Bariatric Surgeon Network or The Memorandum of Understanding
Should be directed to
E-mail: zentralverwaltung7@europe.tricare.osd.mil. Or telephone Mr Hollingworth on 0049-6302-67-6319

TRICARE Area Office, Europe (TAO-E)

Preferred Provider Bariatric Surgery Network

January 2006

Memorandum of Understanding (MOU)

This MOU establishes an agreement between a Host Nation Health Care Provider and the TRICARE Area Office-Europe. The purpose of the agreement is to facilitate elective Bariatric surgical health care when it is not available in a United States military treatment facility.

A. GENERAL:

1. This MOU is entered into by and between TRICARE Area Office-Europe

AND

_____

Host Nation provider (referred to as the Preferred Provider)

2. The MOU does not provide a guarantee or commitment by TRICARE Europe of any specific or general number or level of beneficiary referrals to the Preferred Provider.
3. Under the terms of this agreement, the Preferred Provider is solely responsible for any and all liability incurred as a result of his/her action or omissions, and the Preferred Provider shall indemnify the United States Government from any and all liability.

B. TERMS OF THE MOU:

1. TRICARE Europe will:

a. Designate a TRICARE administrator to assist the Bariatric Surgeon's administrative staff and a clinician to communicate any issues of common interest. These persons will be the only interface for the Preferred Bariatric Surgeon Provider to obtain guidance and authorization concerning the TRICARE Bariatric-surgery medical benefit.

b. Ensure the Preferred Provider's data is included in the TAO-E Central Health Care Finder System under our website: http://www.europe.tricare.osd.mil.

c. Coordinate claims processing in accordance with the below matrix.

	PRIME	Active- STANDARD	Retired - STANDARD
Beneficiary Status	**Active Duty Service Members & their eligible family**	**Eligible family members sponsored by an active duty service member**	**Retirees and their eligible family members**
Inpatient	**100% of all referred covered services or emergency care**	**100% of covered services except for the current daily rate or minimum charge of $25.00.**	**75% of covered services.**
Outpatient	**100% of all referred covered services or emergency care**	**80% of covered services after Fiscal Year deductible has been met**	**75% of covered services after Fiscal Year deductible has been met**

2. THE PREFERRED PROVIDER SHALL:

a. When TRICARE (U.S. government) payment is desired, only provide Bariatric surgery procedures to TRICARE patients that have been pre-approved by TRICARE Europe.

b. Practice no discrimination based upon sex, race, color creed or religion and have the direct or indirect capability to communicate with the TRICARE beneficiary in the English language.

c. Follow these steps to for approval of any elective Bariatric surgery cases involving TRICARE patients:

- Step 1. Obtain patient "Authorization for Release of Patient Information" and send copy to TAO-E along with the pre-surgical assessment.

- Step 2. Submit Pre-Surgical Assessment (include in the pre-surgical assessment an estimated cost) directly to the TAO-E Clinical Operations Section: FAX 0049-6302-67-6377.

- Step 3. Wait for written approval from TAO-E prior to the initiation of any surgery.

- Step 4. Perform the surgery and send operative report and discharge summary to the local TRICARE Service Center. Reports are preferred in English, but type written documents may be provided in the language of the host nation.

d. Establish and maintain medical records for the TRICARE beneficiary and make English language summaries of those records available to the patient. Such medical records will be restricted and protected in accordance with the same form and manner as required by European Union (EU) regulatory controls governing patient privacy or, in the case of non-EU providers, be protected by stipulations set out in an applicable addendum to this agreement.

e. Compile billings priced in accordance with the standards and generally accepted practice of the country where the care is rendered and submit billings not later than 90 days following the date of treatment. Bills must be stapled-once to the back of a completed claim form (DD2424) and the bill contain the following minimum information:

1. Preferred Provider's complete physical and billing address, in letterhead format.
2. Itemization of costs, services and dates rendered.
3. Preferred Provider's Identification Number.
4. The patient's name and date of birth. and the patients' sponsor's Social Security Number
5. The patient's diagnosis.
6. Mail billings directly to:

   WPS-CHAMPUS
   PO Box 8976
   Madison, Wisconsin
   USA 53708-8976

f. Inform TRICARE Area Office, 30 days prior to temporary or permanent cessation of services.

g. Consent to prime source verification of documents and attests, by virtue of signing the MOU, to the accuracy of all information provided.

h. Only perform gastric bypass procedures that are authorized by TRICARE. Currently authorized procedures include: CPT 43844 – Laparoscopic gastric restrictive procedure with gastric bypass and Roux en Y gastroenterostomy, CPT 43846 – Gastric restrictive procedure with short limb Roux en Y gastroenterostomy, CPT 43842 – Vertical banded gastroplasty, CPT 43848 – Revision of gastric restrictive procedure of morbid obesity.

i. Provide appropriate pre-surgical assessment, ensuring a multi-disciplined approach to address any dietary and mental health concerns as needed.

j. Ensure post surgical follow up occurs as appropriate (recommended at 1, 3, and 6 months and then yearly) and contact TAO-E or the local MTF if concerns develop.

C. Administrative Acknowledgements:

1. Provider credentials: The Preferred **Bariatric Surgeon Provider will** provide TRICARE Europe with:
    a) Copy of educational degree(s) attained.
    b) Medical credentials, i.e. medical licenses, registration, specialty board certification, or other authorization (s).
    c) Chronological work history covering at least the last ten (10) years. Any history of adverse clinical privilege and/or disciplinary action by a hospital or civilian government agency, including any subsequent restrictions or limitations on practice, with brief description of the facts of the case.
    d) Copy of malpractice insurance
    e) Evidence of experience in performing Roux en Y procedures. Minimum of 100 total procedures are required with preferably 35 procedures having been performed in the last 12 months.
2. Customer Comment Cards: TRICARE Europe and the U.S. Military Commander will survey patients to provide feedback about the Preferred Provider and staff. These surveys will be based upon non-clinical aspects. The results of these surveys will be shared with the Provider. If any situation deemed unsatisfactory cannot be resolved, TRICARE Europe or the local U.S. Military Commander may immediately exclude (temporarily or permanently) the Provider from the Preferred Provider Network.
3. Complaint Procedures: TRICARE Europe's medical authority will confer with the Preferred Provider concerning issues related to any clinical aspects of medical care provided to U.S. Department of Defense beneficiaries covered by this MOU. Communication will be made with the intent of understanding and correcting the issue. If, in the opinion of the medical authority the issue is of such a nature as to potentially place undue risk on the TRICARE beneficiary the medical authority may immediately exclude (temporarily or permanently) the Preferred Provider from the Preferred Provider Network.
4. Quality Oversight. The Preferred Provider will have a percentage of their cases reviewed by a United States Board Certified Surgeon. Feedback will be available to the Preferred Provider upon request.
5. No parties to this MOU shall assign, transfer, or otherwise dispose of this MOU or any of its interest to any other person or entity.
6. All parties understand that this MOU is not a contract under the United States Federal Acquisition Regulations (FAR) and other United States Federal procurement laws, regulations and procedures.
7. This MOU may be canceled without cause by any of the participating parties upon 30 day written notification to the other parties.
8. The term of this MOU shall (unless canceled prior) be for the duration of the Preferred Provider's license to practice but not to exceed 24 months.
9. The TRICARE Area Office - Europe Director may renew the MOU for an additional 24 months by revalidating the professional credential items listed in C.1.

(a) _____

TAO-E Preferred Provider Signature **Date**

(a) Provider Business Stamp

(b) _____

TRICARE Area Office - Europe Director's Signature **Date**

(b) TAO-E signature block

TAO-E PREFERRED PROVIDER INFORMATION SHEET

Please complete

Provider's data

_____

Title Last Name First Name MI Date of Birth (DD/MM/YY)

Sex: ❑ M ❑ F **Primary Specialty:** _____

a) *Address where care is rendered (Physical Address)*

_____

Street Zip Code City Country

Telephone Numbers for appointments: _____

Telephone Numbers for medical staff: _____

Email for medical staff: _____

Office hours:

Monday: _____ Tuesday: _____
Wednesday: _____ Thursday: _____
Friday: _____ Saturday: _____

b) Billing address for payments and payee's name (if different from the provider's name)

Make checks for this provider payable to: _____

_____

Street Zip Code City Country

Telephone Numbers Accounts/Administration: _____

FAX Numbers Accounts/Administration: _____

Email Address Account/Administration: _____

CREDENTIALS SUMMARY

Please complete

Provider's Credentials

Provider(s) Name: _____

License Number: _____ ***Licensed as:*** _____

Date License Issued: Date License Expires: _____

License Issued By: _____

Individual German providers only: K.V. nummer:

Currently registered with:

Bezirksaerztekammer address: (please provide complete address)

SPECIALTY CREDENTIALS

Specialty: _____

Date Credential Issued: _____ ***Date Credential Expires:*** _____

Credential Issued By: _____